Saskatchewan Health

Investing in quality health services in Saskatchewan

What We Need to Know about Post-Trauma Stress

As health care professionals, you play an important role in recognizing and responding to trauma and its effects. This brochure is designed to provide some clarity about trauma, its impact, and how we can respond most effectively. What really *is* trauma? We use the word "trauma" to describe many feelings and circumstances. We say that we are traumatized by divorce, workplace harassment, the death of someone close to us, being sexually assaulted, experiencing a fire or natural disaster, etc. Clearly these are different kinds of events but each one may include elements of trauma. While it is important not to minimize the distress experienced as a result of these events, some are much more serious on the "trauma ruler" than others. Our reactions to trauma can be experienced on a broad continuum ranging from a general upsetness following a "traumatic" event to much more serious and often long term reactions including Acute and Post-Traumatic Stress Disorders (ASD and PTSD). A victim can experience a number of trauma symptoms without experiencing the debilitating effect of PTSD, but often lesser symptoms can interfere substantially with individual and family coping following a traumatic event. For example, experiencing a serious and/or catastrophic loss (e.g., the death of a child) may not result in a diagnosis of PTSD, but the profound and pervasive impact of such a loss is similar to that of other trauma events that may be diagnosed as PTSD. In summary, we must take care to neither dilute nor unnecessarily limit the meaning, and therefore our response to trauma, because we lack a clear definition of trauma.

Towards a Definition of Trauma

- Trauma can be seen as an all-purpose word for what happens when your world is turned upside down.
- Trauma and our reactions to it can be seen on a broad continuum that ranges on one end, from acute grief symptoms through relatively minor and time-limited reactions to trauma events, to, at its most extreme, Post-Traumatic Stress Disorder (PTSD).
- "True" trauma occurs when the body reacts by turning on its "fight, flight or freeze" automatic pilot in response to situations involving intense fear, helplessness or horror.
- "True" trauma is not the same as severe distress, but rather what occurs when a person is exposed to real or perceived danger, directly (for self), or indirectly (for other) that results in an extreme set of physiological and psychological responses.

The Scope of the Problem

- Lifetime prevalence of post-traumatic stress disorder for general population age 15-54 in 1980's was approximately 1%; in 1990's it has risen to approximately 8%.
- Prevalence of PTSD is significantly higher for females than for males.
- Prevalence of PTSD is significantly higher for those in high-risk professions (e.g., emergency and crisis worker), victims of war and torture, peacekeepers, etc.
- 11% to 23% of all Canadian children witness some violence against their mother in the home.
- Children exposed to women abuse often experience symptoms of PTSD.
- Approximately 6-8% of youth ages 12-17 will experience PTSD.
- 31% of incarcerated young offenders experience PTSD.
- Trauma experienced before adulthood can lead to lifelong impairments.
- Sexual assault results in more PTSD than any other single event.
- PTSD in parents creates greater risk for children because their ability to parent may be affected.
- Many victims who suffer physical injury experience emotional trauma; a large percentage receive no psychological treatment.
- Post-traumatic stress is highly correlated with other disorders including depression, substance abuse, panic disorder and eating disorders.

Characteristics of Traumatic Events

We frequently refer to events as traumatic. A traumatic event is one in which a person experiences, witnesses, or is otherwise confronted with an event that involves actual or threatened death or serious physical injury, or a threat to perceived physical integrity of self or others.

There is a broad range of traumatic events. Trauma can occur following:

- **Single-shot trauma events** (e.g., accidents, murders, suicides, assaults, disasters, etc.)
- **Chronic trauma occurrences** (e.g., physical and sexual abuse, domestic violence, war, torture, etc.).
- **Traumatic loss events** (e.g., sudden and unexpected deaths, violent deaths, death of a child, etc.)

What is Considered a Traumatic Event? Traumatic events are characterized by the following:

- Threat to life and limb
- Severe harm and/or injury
- Receipt of intentional injury or harm
- Exposure to grotesque, violent or sudden loss of a loved one
- Witnessing or learning of violence to a loved one
- Causing death or severe injury to another

What Can Cause Post-Traumatic Stress? Because we respond to them so frequently in our work, we sometimes fail to recognize post-traumatic stress in the following circumstances:

- Witnessing domestic violence.
- Fear and fundamental lack of safety in children living with chronic parental addiction or other situations engendering anxiety, fear and insecurity.
- Losing access to an absent parent or to a primary caregiver whoever that person may have been (e.g., grandparent, aunt, etc.).
- Being arrested; being kept in isolation in a custodial facility.
- Being the victim of peer violence, emotional or physical.
- Witnessing or having knowledge of the suicidal intentions or attempt of a family member, especially a parent.

It is important to remember that reactions to trauma are not solely determined by events; rather there are a number of other factors to be considered including past history of trauma and coping strategies.

Why People React Differently to Trauma

A number of factors affect how people will respond to trauma. Some of the more significant ones include:

- Severity, magnitude, and proximity of the trauma event and how prolonged it is
- Degree of fear, helplessness, powerlessness, and horror
- Past history of trauma, loss and coping
- Degree and meaning of relationship with those most affected, and intensity of the loss
- Degree of, and accessibility of support in the environment - family, social, community.
- General ability of victims to cope with emotionally challenging situations

Major predictors of more serious long-term problems following trauma include the nature and magnitude of previous losses and trauma (especially childhood trauma), and effectiveness of coping strategies.

TIPS FOR RESPONDING TO TRAUMATIZED INDIVIDUALS

There are a number of tips for responding to traumatized individuals. Some are general and others are more specific to how much time has passed since the traumatic event(s).

General Tips for Responding to Traumatized Individuals	Immediate Post-Trauma Intervention Tips	Intermediate and Long Term Post-Trauma Intervention Tips
• Responses to trauma must be offered with respect, sensitivity and careful attention to timing and pacing, taking into account clients' needs. • A comprehensive assessment of trauma and loss provides the essential base for ANY response. Lack of a good assessment can lead to no response or inappropriate responses such as encouraging emotional expression of grief when post-trauma symptoms including intrusive imagery may require emotional containment. • Generally speaking, following a comprehensive assessment, we must treat the trauma symptoms before addressing grief issues. • We must be careful not to push victims of trauma to ventilate their feelings, but we should give clear permission for discussion of feelings and be prepared to hear horrifying details if the victim wishes to share them. • We may need to help victims "contain" intense emotional responses. • "Single-shot" interventions should be avoided. Good overall assessment should provide indicators for possible short- and long-term appropriate interventions that fit the needs of the client and the situation. • Group interventions, such as debriefings, are not necessarily good for everyone, and victims of serious trauma should be assessed for post-trauma symptoms before being invited to such interventions. We may do more harm than good by bringing up reminders of an event the victim may be struggling to avoid in attempt to manage the emotional impact. • Trauma is an experience of dis-control. Every effort in early or integrative interventions should facilitate the re-empowerment of victims. • Victims of trauma often feel unsafe physically and psychologically. Our interventions should enhance feelings of safety, sense of security and competence. • Trauma is an experience of disconnection; interventions should facilitate natural support linkages/connections (family, social and professional) wherever possible, while encouraging new ones where necessary (e.g. support groups, clergy, counsellors, etc.) • Caregivers can be "part of the problem" rather than "part of the solution" if we mis-assess or minimize the impact of victims' experiences.	• Use basic crisis intervention skills to provide stabilization and practical as well as emotional support. • Attend to physical and psychological safety issues first. • Allow victims to talk about their experiences if they wish; do not probe for emotional reactions; feelings may be the one aspect of their lives they feel in control of. • Normalize the victim's experience of his/her symptoms and provide brief information (including written) about current and possible future effects. • Minimize and manage post-trauma symptoms, especially physiological stress and intrusive imagery, where possible. • Facilitate connections with resources including family, friends, other professionals, etc. • Assess for further needs regarding post-trauma stress and loss. • Empower victims with choice, recognizing that they may only be able to make limited choices, not global ones. It may be helpful to ask victims: "What do you need to cope right now?"	• Do a thorough history and assessment. • Ensure that assessment includes the impact of both trauma and loss (where indicated) in order to determine which component to address first (e.g., grief counselling will not be effective while victims are suffering from post-trauma symptoms). • Normalize the victim's experiences of his/her symptoms. • Provide a framework for symptoms that help victims to understand what has happened to them. • Assess for distressing symptoms and assist with symptom reduction and management. • Teach about identification of trigger experiences, as well as symptom reduction and management techniques. • Use current therapies known to be effective with different aspects of post-trauma reactions and complicated grief responses where indicated. • Take care with pacing and timing interventions and involve client in determining same.

RECOGNIZING TRAUMA: SIGNS AND SYMPTOMS

Trauma symptoms can be managed and often minimized if we know how to identify them and intervene appropriately. Learning to live with the sometimes profound and pervasive changes in one's personal identity and everyday life following serious trauma and traumatic loss are more difficult and long-term issues.

Immediate Symptoms	Intermediate Symptoms	Long-Term Symptoms
• Shock and denial, and feeling numb or disconnected, are typical responses to trauma and disaster. They are normal protective reactions. • Thoughts and memories of the event, often accompanied by physical reactions, may occur. • Physical symptoms that may accompany extreme stress include changes in heart rate, and breathing, nausea, chest pain, etc. Victims may also feel restless and "on alert", and respond quickly to environmental cues that remind them of the trauma. Pre-existing medical conditions may be worsened and some symptoms may require medical intervention. • Sleeping and eating patterns may be disrupted. Victims may have difficulty falling asleep, staying asleep, or being troubled by frightening dreams. • Feelings may be very intense and hard to modulate, and unpredictable. They may include confusion, irritability, anger and even rage, fear, anxiety and nervousness, feeling detached and "unreal". • Victims may find it difficult to remember, concentrate, or make decisions; some have difficulty recalling parts of the trauma experience. • Acute Stress Disorder (ASD) and its symptoms of arousal, intrusion and numbing or dissociative symptoms may be experienced during the first month following the traumatic event.	• Some people respond immediately to trauma; others have delayed reactions weeks and months later. • Intense emotional reactions are common and are frequently triggered externally by sights, sounds, smells, etc., and internally by memories, feelings, body sensations, etc. • Triggers may be accompanied by fears that the trauma event will be repeated, or victims may feel it is happening again. • Panic attacks may occur when victims experience triggers. • Interpersonal relationships may become strained. • Greater conflict coupled with irritability and anger may occur. • Victims may experience a diminished sense of safety, trust and confidence. • Victims might become withdrawn and isolated, avoiding usual activities and losing their sense of enjoyment and purpose in life. • Acute Stress Disorder (ASD - within the first four weeks) and Post-Traumatic Stress Disorder (PTSD – if symptoms persist longer than one month) symptom clusters of arousal, intrusion and numbing or dissociation may be experienced.	• Both immediate and intermediate symptoms may persist over the long-term. • Many of the symptoms of PTSD as outlined in DSM-IV may be experienced. • Generalized hyperarousal and difficulty in modulating feelings/behaviour are common problems. • Conditioned fear responses to trauma-related stimuli may interfere with normal functioning. • Trauma victims frequently experience problems with memory and concentration. • They also experience emotional detachment and sense of depersonalization. • Victims may experience a shattered sense of meaning followed by a loss of safety, trust and competence in themselves and the world. • Post-trauma relationships are often characterized by anger and mistrust. • Withdrawal and isolation from social relationships, inability to maintain relationships, and difficulty in parenting present common long-term difficulties.

General Reactions to Trauma and Loss

- Trauma produces inner wounds not visible to the outside observer. Trauma victims often feel "crazy" and will not disclose symptoms unless they are normalized and permission given to discuss them.
- Trauma survivors frequently do not tell us about their experiences because they feel they should not burden us with the horror of them. We in turn, often have great difficulty in hearing their stories.
- Identifying, assessing and responding to victims of trauma and loss does not mean that they remain victims. Trauma and loss are external factors that transform the lives of those affected by them; victims have tremendous resilience to cope with and heal from trauma.
- Caregivers are an important part of the "recovery environment" of those struggling with the impact of trauma and loss. We must offer our services with respect, sensitivity and knowledge.

Context for Assessing Trauma

- Trauma experiences can affect how we function in all areas of our lives - cognitive, emotional, physical, spiritual and behavioral/social.
- There is no one "standard" pattern of reactions to the extreme stress of traumatic experiences. Some people respond immediately, others have delayed reactions over a period of weeks, months and even years.
- Some experience adverse effects for a long period of time while others recover quite quickly. Serious life events such as accidental deaths, suicides, murders, sexual assaults, war, etc. are experiences that we do not just "get over". They may leave long-lasting scars.
- All loss involves some degree of trauma, and all trauma involves a substantial amount of loss and grief.

Common Misconceptions in Understanding Trauma

If it looks OK on the outside, it must be OK on the inside.	"Good coping" may be indicated in a variety of ways including "numbing out" and being "OK". Showing no response or little response to trauma events is often an indicator of the need for coping through denial. Most reactions to trauma, whether they are intense emotional reactions, or avoidance and numbing reactions are normal, especially in the short-term.
Trauma symptoms are a sign of pathology.	Trauma symptoms are functional and can be seen as signs of the person's system trying to re-establish its equilibrium. They are signs of health, not illness; they serve important functions that reflect the victim's need to both recognize the reality and impact of the trauma, and also to deny what is overwhelming and unbearable.
All mental health workers are trained to assess and intervene with trauma.	Many professional training programs offer little in assessment and treatment of trauma and loss; many caregivers have little knowledge or experience in these difficult and overlapping areas.
Loss, grief and trauma are the same things.	All trauma inherently contains substantial elements of loss, and all losses involve some degree of trauma. They frequently look similar, especially in the acute phase immediately following the trauma event. However, they also involve different processes and require treatment appropriate to each. Trauma is frequently an overlay on the grief process, and may interfere with grieving and mourning if it is not addressed separately.
We should wait until victims seek help.	Countless client stories lend support to the need for proactive trauma support immediately or in the early weeks and months following a trauma. For example, a mother who has just witnessed the violent death of her child, or the nurse who tried to save that child's life may both benefit from support and immediate trauma intervention. Remember that victims of trauma are struggling to maintain or re-establish a sense of equilibrium; they want to appear as competent and "in-control" as possible. Given this, seeking out help may be difficult indeed.
Communities always managed trauma in their own ways before; we should not interfere.	It is important to recognize that it is an assumption, not a fact, that people seemed to cope with these experiences on their own in the past. History and literature are full of references to not only traumatic events, but to the long-term devastation experienced by its victims, both personally and in community.
If a person survives an accident and recovers physically, they must be well. They should be happy they are alive.	Psychological trauma occurs in a large proportion of serious physical injuries but often does not become evident while the victim's energy is going into physical recovery. Post-trauma reactions are often identified when physical equilibrium has been re-established. However, most victims of physical trauma are not assessed for psychological trauma, nor offered appropriate services.

Roles of Health Professionals

The roles of health professionals in responding to trauma are varied. Responsibilities may include assessment, intervention, treatment and consultation to other service providers who have the primary responsibility for intervening and supporting clients experiencing post-trauma stress. For further information on addressing post-trauma stress you may wish to call mental health services in one of the following health districts:

La Ronge
Mental Health Services
Mamawetan Churchill River
Health District
Box 6000
La Ronge, Saskatchewan
SOJ 1LO
PH: 425-8500
FAX: 425-8550

Melfort
Mental Health Centre
North Central Health District
Melfort Hospital
Box 1480
Melfort, Saskatchewan
SOE 1A0
PH: 752-8767
FAX: 752-8711

Moose Jaw
Mental Health Services
Moose Jaw-Thunder Creek
Health District
455 Fairford Street East
Moose Jaw, Saskatchewan
S7H 1H3
PH: 691-6464
FAX: 691-6461

North Battleford
Child & Youth Services
Battlefords Health District
Don Ross Centre
891 – 99th Street
North Battleford,
Saskatchewan
S9A 1E9
PH: 466-6555
(Child & Youth) or
446-6500 (Intake)
FAX: 446-8765

Northern Saskatchewan
Mental Health Services
Keewatin Yathe Health
District
Box 40
Buffalo Narrows,
Saskatchewan
SOM OJO
PH: 235-2220
FAX: 235-4500

Prince Albert
Prince Albert Mental Health
Centre
Prince Albert Health District
Victoria Square Building
Box 3003
Prince Albert, Saskatchewan
S6V 6G1
PH: 765-6055
FAX: 765-6017

Regina
Child & Youth Services
Regina Health District
1601 College Avenue
Regina, Saskatchewan
S4P 1B8
PH: 766-7400
FAX: 766-7888

Rosetown
Mental Health Centre
Midwest Health District
Box 2054
Rosetown, Saskatchewan
S0L 2V0
PH: 882-6408
FAX: 882-6474

Saskatoon
Child & Youth Services
Saskatoon Health District
715 Queen Street
Saskatoon, Saskatchewan
S7K 4X4
PH: 655-7800
FAX: 655-7811

Swift Current
Child & Youth Services
Swift Current Health District
350 Cheadle Street West
Swift Current, Saskatchewan
S9H 4G3
PH: 778-5250
FAX: 778-5428

Weyburn
Mental Health Services
South Central Health District
Community Services Building
P.O. Box 2003
Weyburn, Saskatchewan
S4H 2Z9
PH: 842-8665
FAX: 842-8690

Yorkton
Child & Youth Services
South Central Health District
270 Bradbrooke Drive
Yorkton, Saskatchewan
S3N 2K8
PH: 786-0558
FAX: 786-0540